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ABSTRACT

A description of the Youth Services Demonstration Project currently being conducted at Alcoholism Services of Cleveland is presented. The family systems approach model used by the project incorporates the following procedures into a multiphase program: (1) assessment and contracting sessions; (2) selection of one of three possible treatment courses; and (3) follow-up and evaluation of the program. Special issues related to the implementation of this family systems approach include acceptance of the family focus, counselor awareness, choice of co-therapist, and flexibility in treatment planning. Each phase of the treatment is described in detail for the reader. (Author/HLM)

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# A MODEL FOR A FAMILY SYSTEMS THEORY APPROACH TO PREVENTION AND TREATMENT OF ALCOHOL ABUSING YOUTH

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# A MODEL FOR A FAMILY SYSTEMS THEORY APPROACH TO PREVENTION AND TREATMENT OF ALCOHOL ABUSING YOUTH

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Within the field of alcoholism treatment, there has been an increasing concern about problem drinking among teenagers. A concurrent interest in involving family members in treatment has been growing as well. We would like to briefly review some of the literature that supports a family systems theory approach to treatment of alcohol abusing youth. Our backgrounds in alcoholism and family treatment combined with recent experiences with the Youth Services Demonstration Project currently being conducted at Alcoholism Services of Cleveland have led us to the development of a family systems model for that population. This paper will describe the various components of the model, special issues involved in its implementation, benefits derived from its use and our conclusions.

## THEORETICAL OVERVIEW

Family systems theory has been applied to emotional problems in the mental health field for over twenty years. Though alcoholism has often been described as a family illness, the family systems approach has only recently been recognized as a possible treatment of choice. In order to show how this approach would be particularly applicable for alcohol-abusing

youth, it will be necessary to examine some key concepts and principles of family systems theory.

When the family is viewed as an operational system, "change in the functioning of one family member is automatically followed by a compensatory change in another family member". (Bowen 1973) Like other systems, a family will seek to maintain a sense of balance or homeostasis. The system as a whole will function at different levels of efficiency in response to changes in the functioning between its members. If one member of a family becomes ill, the others will have to overfunction to compensate in order to avoid system failure. Behavior is examined within the context of the field of interactions among family members. "Systems theory attempts to focus on the functional facts of relationships. . . what happened, how it happened, and when and where it happened. . .It carefully avoids man's automatic preoccupation with why it happened." (Bowen 1974) It is believed that such cause and effect thinking promotes blaming others for one's problems. Family members are likely to resort to such blaming when the level of anxiety in a family increases. Problems with alcohol can be displayed as dysfunction in one member but each family member plays a part in maintaining an overall functional imbalance which can lead to a vicious circle of blame and intolerable emotional pain. Therefore, in order to use a family systems approach, the entire family must be viewed as the client rather than as collaterals to the alcoholic.

Authors in the area of adolescent alcohol use seem to agree that there is a great deal of difficulty in defining what constitutes problem drinking among teenagers. Part of the difficulty arises from the wide range of behaviors being considered, beginning with the fact that most teenage drinking is illegal in itself and including young people with actual signs of addiction. However, few of the alcohol-abusing youth encountered in treatment programs meet the traditional definitions of alcoholism. Some investigators have shown that these young people resemble the early drinking patterns of older alcoholics at the same age. Others remind us of the potential for an adolescent to outgrow these destructive behaviors and therefore often advise treatment agencies to beware of stigmatizing youth with hasty diagnoses.

Although we are presently unable to identify which combination of variables could serve as reliable predictors of continued problem drinking for these teenagers in later life, the primary family has long been cited as having a significant impact in the formation of attitudes and behaviors related to alcohol use. One study by Pendagast and Schaefer (1974) suggests that rather than parental attitudes towards alcohol use or their own drinking behaviors, "it is the parents' attitudes and behaviors toward the child (as perceived by the child) which show the strongest correlation with the child's drinking behavior". The study found

lack of control by the mother and psychological tension with feelings of rejection in the relationship with the father were often reported in the family where an adolescent drank excessively. On the other hand, Dr. Morris Chafetz (1975) has emphasized the importance of the adult example. "Most drinking by youth is a move toward adult patterns of behavior, not rebellion against parents". Nevertheless, there is still a clear implication of the poignant influence within family interactions.

The speakers at the 1976 NCA Conference on Adolescent Alcohol Use stressed a need for an honest and positive approach to the reality of teenage drinking. At that meeting, Dr. Don Cahalan suggested less concentration on symptomology in favor of looking at adolescent drinking problems. . . "more from the perspective of specific interpersonal problems in environmental situations which tend to exacerbate these specific problems. . .". The members of the NCA panel felt that the percentages of teenage alcoholics would be much lower than it is currently being represented by the media. Outpatient treatment in such cases has been very similar to the adult alcoholic with the additional recommendation that family involvement is essential. A family systems approach can be effective with teenagers who abuse alcohol for several reasons. The entire relationship system is examined to determine what destructive behaviors are present and what reactive behaviors in others perpetuate

them. In the process of intervention, treatment can focus on family members who are the most motivated and have greater resources to change. And finally, by subtle but consistent messages which re-frame the problem within the family system, the treatment avoids the endless resistance and stigma surrounding the label of teenage alcoholic and allows programs to serve a wide population.

## THE PROGRAM

### Setting and Population

Alcoholism Services of Cleveland is a private non-profit service agency established through a consolidation of the Cleveland Center on Alcoholism and The National Council on Alcoholism, Greater Cleveland Area. It has a history of direct treatment and consultation which spans more than two decades. Current functions within the agency include information and referral, community education, family oriented direct service, professional training, occupational programs and a youth services demonstration project.

Prior to the beginning of the operation of the Youth Services Demonstration Project, ASC had been accepting referrals of young people having problems with alcohol. However, with the addition of the specialized services for youth, outreach efforts and building contacts with other youth serving agencies were intensified. This project is

committed to providing services as well as gathering and interpreting data on effective treatment methods with this population.

The Juvenile Court has served as the primary source of referrals for the project as a result of previous positive relationships with the agency. School and self referrals have been increasing along with community education. The age range is limited to 15 - 18 years old for the purpose of this demonstration and for appropriate composition of treatment groups. To date, treatment population has been approximately 90% males and 10% females predominately from middle class families.

## Assessment Phase

Initial contact is generally made by the referral source. At that time a brief description of the program is given including our expectations for family involvement. An effort is made to engage that worker (e.g. probation officer) in continued involvement in assessment, treatment planning and support of implementation efforts. The referring worker's involvement begins with contacting the family, explaining briefly our family focus and instructing parents to contact us.

When the family contacts us, usually through a phone call made by one of the parents, they are given an initial assessment appointment. They are encouraged to bring as many family members as possible, but at least one parent must accompany the young person who has been referred. In

some instances, the referring person may also be involved in the actual assessment sessions. The transition is thereby facilitated from another agency to ours and the support of the referring person aids in commitment to treatment with us.

We have found that a minimum of three appointments is ideal for the assessment process. It is less overwhelming to the family. Additional members may join in the ensuing appointments. It also allows for the passage of time necessary to develop a broader perspective of family functioning, and the surfacing of initially suppressed or hidden issues. For example, in the first assessment interview, a family may be highly resistant to following the court's recommendations for treatment at an "alcoholism" agency and report that there are no problems in this area. During the time between the first and second interviews, one member having thought about the issues raised, may be willing to risk sharing a relevant concern.

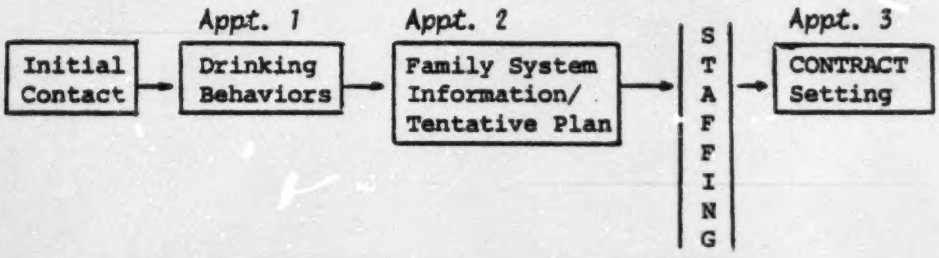


FIGURE 1 - THE ASSESSMENT PHASE OF THE PROGRAM

First Assessment Session

The aims for this session are: first, to foster engagement through what Guerin and Pendagast (1976) refer to as an

emotionally validating experience; second, to obtain basic drinking behaviors information on all family members; and finally, to obtain basic family system information.

The family fills out a face sheet while waiting to see the counselor. This form supplies basic demographic information about the family which serves as a useful tool for introducing the family to the therapist as well as providing a comfortable method for getting started. Once the information in the form has been reviewed, every family member is asked to state the presenting problem as he or she sees it. They are also asked what their expectations are for involvement with the program. A drinking practices questionnaire is given to each member and responses are discussed in a non-judgmental way for the purposes of clarifying the data and educating the family members about concepts and terms used. The session is reviewed and summarized and a second assessment appointment set.

A basic practice consideration at this point is that it is best not to push the "family" approach too hard. As Guerin and Guerin (1976) point out, "in a child-focused family it is important not to fall into the trap of trying to sell the parents the idea that what they have is a family problem or a marital problem. Any such attempt only triggers already primed feelings of parental guilt and responsibility and the result will be an increase in the family's anxiety level and a reinforcement of denial and projection".

It is important to paraphrase, clarify, and summarize each family member's statements about the presenting problem and their expectations. "The therapist must make a personal connection with each family member present (and to) communicate an understanding of each family member's position vis-a-vis the presenting problem. The evaluation session then becomes an emotionally validating experience for the family and as such fosters the process of engagement". (Guerin and Pendagast 1976).

Second Assessment Session

During this session, the worker gathers more family systems information through the use of a genogram. A treatment plan is proposed and the process of staffing their case is explained. The process of engagement is continued through the construction of the genogram by the family. It is a good way to gather information on the family and, if all family members are involved, subtly promotes the family systems focus by filling in 3 generations and significant historical events.

Having clarified problem areas needing work, the family engages in the development of a tentative treatment plan. The counselor provides input and guidance and explains the case staffing process which will precede final contracting for treatment. Special care must be taken during this explanation. Potentially, family members can become anxious when told that their family's case will be presented to the

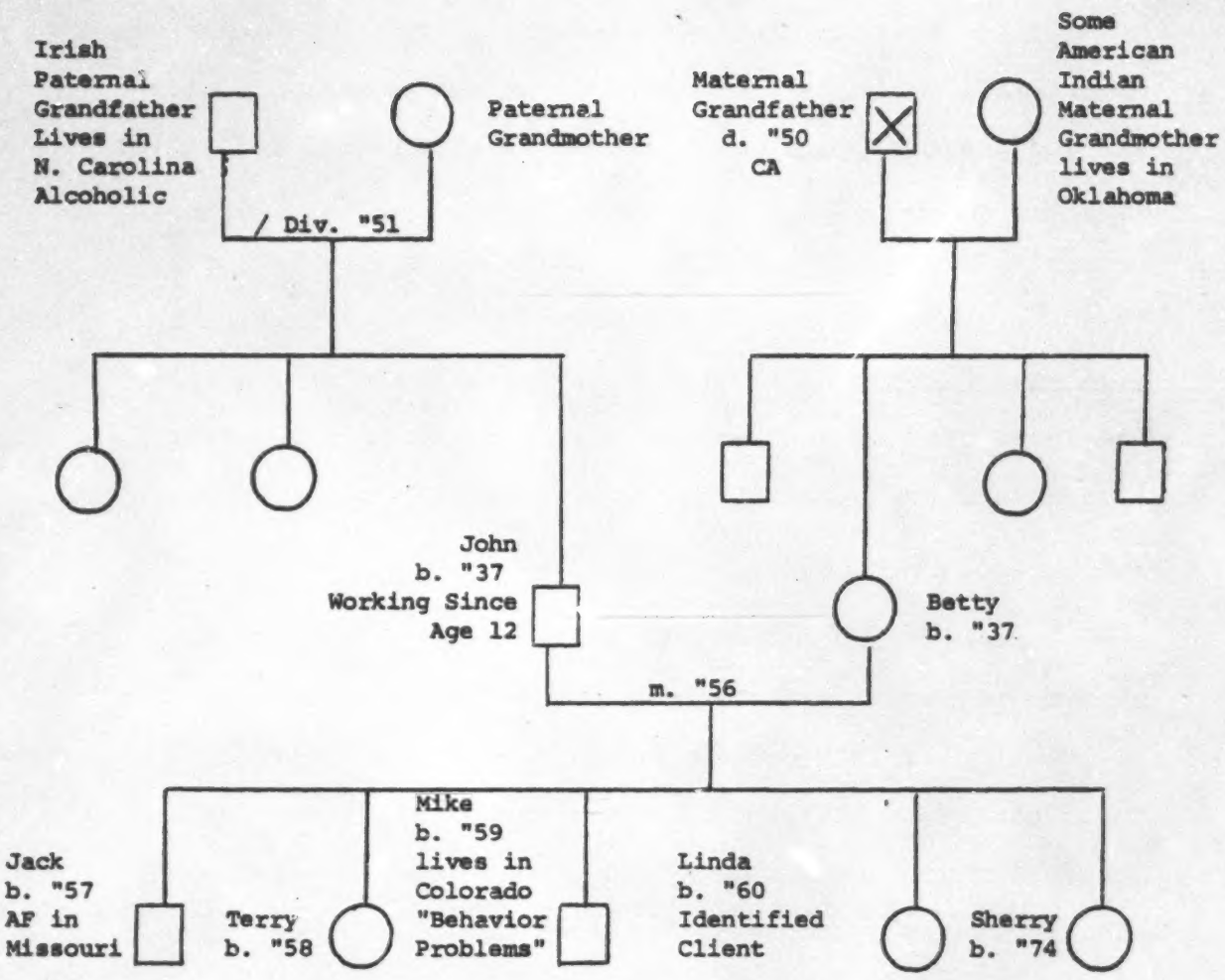


FIGURE 2 - SAMPLE GENOGRAM

rest of the treatment staff for feedback. If presented poorly, the thought that "6 or 8 total strangers are going to examine us" may well arise. Helpful ways of overcoming this anxiety include a description of the confidentiality regulations that govern the agency and the positive benefits to be derived from staffing.

Contracting Session

At this session there is a review of progress to date. Any modifications to the treatment plan suggested by the staff are discussed and a final treatment plan is developed. A treatment contract is formulated by the family with the counselor. All members give their input and all sign the document. The family treatment contract is similar to any such agreements used for treatment. It includes problem statements, therapeutic goals, methods to be employed, fees, meeting dates, responsibilities of the family and the counselor, etc.

The treatment portion of the program evolves from both of the variables explored in the assessment phase; the severity of problem drinking displayed by the teen and the degree of family system dysfunction. We propose three courses of treatment be used to address these variables because of their range. For the purposes of this paper, we will label them courses A, B and C.

## Treatment Phase

Course A

This course is the major portion of the program and provides outpatient services to young people who are experiencing on-going problems with alcohol. It is intended to serve families where some level of family system dysfunction is evident and appears to be perpetuating the abusive drinking.

During this course a number of positive outcomes are sought. Family members will increase their knowledge of alcohol and drug use and have a heightened awareness of its consequences. They will acquire skill in discussing interpersonal issues before crises occur and become aware that behavior can be controlled through self initiated planning for change. There will be a reduction in the use of the blaming system. Parents will improve ability to discriminate between appropriate limit setting of behaviors which are transactional vs. attempts to control thoughts and feelings which are private. (Berenson 1976).

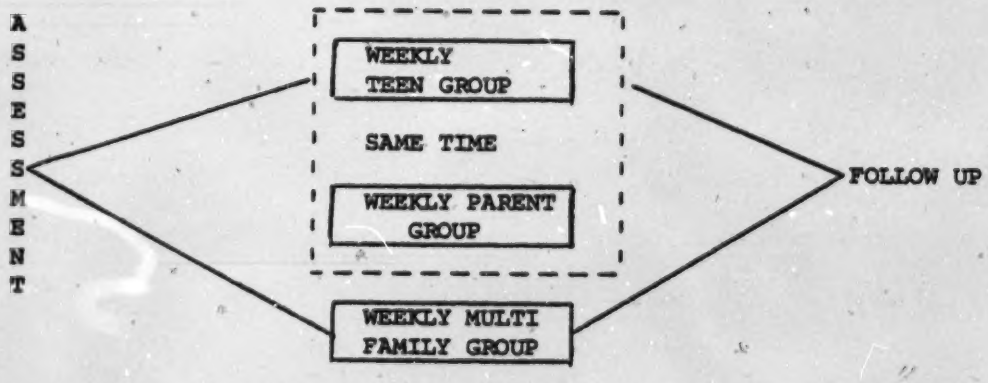


FIGURE 3 - COURSE A PARADIGM

The paradigm calls for the meeting of three groups per week. A peer group for the teens meets one evening of the week. Issues dealt with include; peer pressure, values, alternative highs, school adjustment, and use of leisure time.

An executive subsystems (parents) group is run at the same time as the teen group. This serves to avoid emphasis on an identified client and allows an opportunity to deal with important parental subsystem issues (e.g. sexual concerns, parenting, etc.). Scheduling both meetings simultaneously helps promote regular attendance, strengthens the total family's commitment to treatment and alleviates transportation conflicts.

On another night later in the week, there is a third session which is a multiple family group. Issues dealt with in this group include alcohol and drug education, alcohol abuse and alcoholism, orientation to A.A., Alanon, and other self help groups, family systems functioning, dealing with stress, enhanced communication, behavioral contracting, and positive relationship building. Should any individual or family fail to appear for any of their meetings, a phone call might be made. This maintains continuity and provides the counselor with immediate information regarding the absence.

In these open groups, families enter and leave depending on the previously contracted-for period. At the end of each family's contract period, a family session is held for renegotiation. If it is decided additional work is needed, such as further treatment or referral, the appropriate action is taken. If termination is agreed upon, then the family is placed in follow-up status which insures continued contact between the counselor and the family at 90 day intervals.

For an illustration, let us look at the profile of a client who would be appropriate for Course A and her treatment:

> Cathy K. was referred by her probation officer at Juvenile Court based on several alcohol related incidents. However, she had ceased all drug experimentation and drinking had decreased to a minimal level at time of referral. She had dropped out of high school within the preceding year and was employed at a hamburger stand on a part-time basis. In the drinking history, she admitted to multi-substance abuse, blackouts, dramatic weight loss, poor school performance, loss of friends and decrease in tolerance. Her father was clearly alcoholic and the parents were in the process of divorce.
>
> Although Cathy had only recently improved her physical condition and behavior, we decided to try her in Course A of the outpatient program since she demonstrated some compliance and the family was supportive. Mrs. K. would attend the parent's group alone. Mrs. K. agreed to attend the family group with Cathy's younger sister and Mr. K. was willing to provide Cathy's transportation to the teen group. The family identified issues of the divorce, father's impending remarriage, mother and the daughters move to a condominium and mother's dating as areas to deal with in group. During the course of treatment, Cathy herself worked on staying "straight", constructive leisure time activities, controlling her temper and considering a vocational evaluation in addition to getting a high school equivilancy degree. During the second three months in the program, attendance has diminished since Cathy found a satisfying full time job and the family feels more stabilized. She has been taken off of her probation and there have been no further legal infractions. Her younger sister began attending Alateen meetings.

Course B

There are some cases where alcohol/drug abuse in the teen and family system dysfunctioning are so severe that outpatient treatment is not appropriate. Immediate and intensive intervention is then required. Most of the time this takes the form of the teen being referred to residential

treatment with the balance of the family also involved in treatment either at the residential facility or in this program.

The most important goal in this course is to interrupt the destructive drinking and to repair any physical damage. Then the functioning of the family members most capable of change must be enhanced and a plan for continued treatment must be developed.

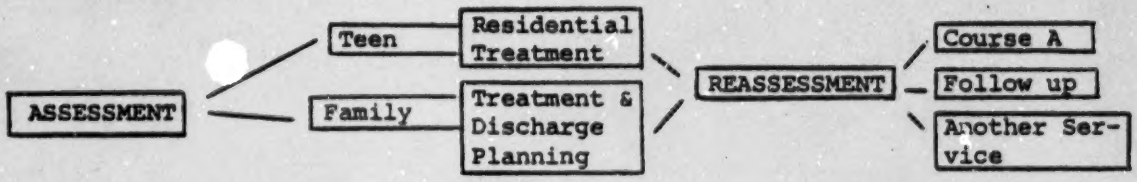


FIGURE 4 - TREATMENT COURSE B

As in the other courses, as many family members and significant others as possible are recruited. They are presented with the facts of the teen's illness and engaged in supporting referral to treatment. They are informed about the treatment facility chosen and referral is facilitated. All are engaged in the development of a treatment plan for the whole family while the teen is in treatment and at the point of discharge.

The client and family described below demonstrate when Course B is appropriate:

> Kevin M. and his family went through the assessment phase but it was agreed that outpatient treatment would not be effective. He had been referred by the school officials and his parents when the family was experiencing a severe crisis about Kevin's abuse of alcohol and other substances. There had been numerous dramatic confrontations at home, Kevin was doing poorly in school, there was a great deal of anxiety regard-

ing his self destructive potential, and the family situation was generally chaotic. Since Kevin had been placed in a generic residential treatment facility several years prior to this contact and the parents had a history of "agency-hopping", referral to an inpatient alcoholism unit was presented as the treatment of choice.

The parents were aided in dealing with their own ambivalence through a Johnson Institute type session involving representatives from the school and by sharing printed information from an adolescent treatment program in a near by city. Kevin, who was also present at the meeting, was able to ask questions about the admission process. All parties were involved in planning for aftercare as well as contingency planning if Kevin did not complete the treatment at the program. The Counselor served as a coordinator between the various systems and the parents were engaged in the appropriate phases of the project immediately.

Course C

The families using this course are those in which the teens have a one time incident of high risk drinking behavior but the family is still functioning at adequate levels. Many of these families are referred as a result of the teens first DWI offense. For this group a secondary prevention approach is taken. A multiple family alcohol prevention series has been developed. It is a closed ended group with a distinctly educational focus.

All family members learn about alcohol and alcohol related attitudes and behaviors. They learn to recognize when a problem with alcohol exists and what to do about it. Skill is developed in making intelligent and rational decisions about drinking that will be most constructive. They become aware of the immediate and long range consequences of alternative patterns of behavior and learn how every act of be-

havior related to alcohol has multiple causes. Finally, they come to understand the relationship between their behaviors and those of others in their families. Of course, all of these learning objectives are directed toward elimination of the destructive behavior(s) related to alcohol which necessitated referral to ASC and general prevention in the rest of the family members.

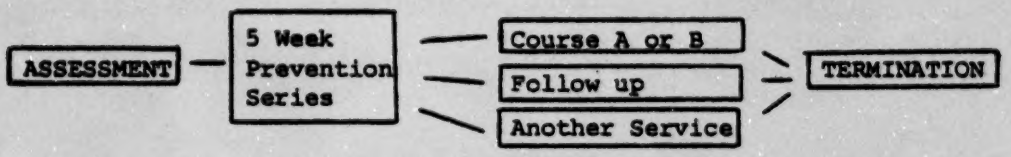


FIGURE 5 - TREATMENT COURSE C

The group experience is comprised of five 1½ hour weekly sessions. Films, lectures, exercises, and homework assignments are all used to convey the information and to help each individual internalize it. A major feature of the series is the family action plan. This is a document prepared by each family which outlines specific methods whereby the family unit will support responsible attitudes and behaviors by each of the members.

SAMPLE ACTION PLAN

To determine our relationship with alcohol as it affects our lives, our family and others and to establish ground rules for responsible use of alcohol, we agree:

I.

A. Until 18, no drinking of alcohol unless supervised by parents.
B. At 18, drinking of 3.2% beer, without supervision of family, but not to excess.
C. At 21, drinking complete responsibility of the individual, and it should not interfere with their life activities or others lives.

D. Keeping in mind the effects of alcohol on mind and body, drunkeness will not be acceptable behavior.
E. If driving skills might be impaired, alternative transportation will be used.

II.

A. Each of us will try one new leisure time activity or else take steps to improve on an old one.
B. We will try to discuss what our needs are and negotiate when necessary.

III.

A. We will try to share our problems and worries before they are too big.
B. We will try to be responsible for our own behavior.

IV.

A. We will share our new information about alcohol use and abuse with friends.
B. We can set good examples.
C. We can tell people where help is available if they need it.

Signatures _____

_____

Following the completion of the series, the family is transferred to inactive status. A follow up appointment occurs one month later to check on any need for further contact. Any number of additional problems might have surfaced at this point. A previously hidden drinking problem in one or both of the parents may be revealed. In this case, the family is integrated into the adult service component of the agency at the appropriate level or the family is referred for additional family systems work elsewhere.

## SPECIAL ISSUES

We have identified four special issues related to the implementation of a family systems model. They include; acceptance of the family focus, counselor awareness, choice of co-

therapist, and flexibility in treatment planning.

First. In order to be effective, a family systems approach must be applied consistently. This requires more than an intellectual acceptance of the theoretical perspective. Counselors must believe in its value and their ability to apply it. With consistency, certain techniques such as rephrasing and redefining process in family terms become almost second nature. It is the subtle but consistent projection of this perspective which enhances the likelihood of a family buying the family treatment approach.

Second. In any therapeutic process, there is an inherent danger of counselors becoming hooked into the emotional intensity of the problem or interactions of individuals within a family. It is necessary for counselors to be aware of their position vis-a-vis the client family and to be aware of influences from their own family. Equally, counselors need to deal with their attitudes, values, and anxieties related to alcohol problems. This necessitates the counselors' continuing examination of their drinking behaviors, the purposes they serve in their lives and their families. (Carter 1977).

Third. The group work literature cites a number of reasons for using a male-female co-therapist team. All these apply to the groups conducted in this model. Additionally, if the co-therapist team is male-female, they have a broader repetoire of experiences in role relationships.

Finally, flexibility in treatment planning and continued assessment past the formal assessment stage are encouraged. Since the primary course of treatment is composed of open groups, families can be readily referred into them as the case warrants. In some families as in the case where parental alcoholism is discovered, continued treatment in this model may not be as appropriate as referral to and coordination with adult services.

## BENEFITS OF THE PROGRAM

The benefits of using a family systems model for the treatment of teenagers with alcohol related problems extend not only to the adolescent but to the other family members, the family as a whole and to the helping person as well. In the multiple family group setting, there is less need to be defensive since blaming is arrested and every person is encouraged to take responsibility for their own behaviors. It is easier to view the family situation more objectively if it is reflected in other group members. This minimizes the feelings of isolation and hopelessness at the same time. Parents and their children begin to adjust their perceptions and relationships when provided with new information and coping mechanisms. Even small changes in these areas can provide a basis for positive family functioning to continue in the future. In addition to more effective engagement and continuity in treatment, families are made aware of a resource for consultation should the need ever arise again.

There are some obvious advantages to this approach for the person providing the treatment. The helping person gets a more realistic view of the family's situation with less distortion and greater confrontation of denial. However, as Bowen (1976) reminds us, it is essential that both counselors always be tuned-in to their own position in the emotional system when dealing with families. "A basic principle in this theoretical-therapeutic system is that the emotional problem between two people will resolve automatically if they remain in contact with a third person who can remain free of the emotional field between them, while actively relating to each". A conscientious application of systems theory requires constant self-evaluation on the part of helping persons. In this way, they can more freely move between seriousness and casual comments when appropriate to facilitate treatment. Similarly, choosing among a number of techniques which range from being directive to those which let the clients maintain ownership of their problems will be based on analysis of the family process within the system. It will not be the counselor's own reactive response to an overwhelming situation or reverting to comfortable patterns without purpose.

## RECOMMENDATIONS

A family systems approach to the treatment of alcoholism is relatively new. In order to assess the efficacy of the approach, programs using it need to have a rigorously designed evaluation component. Indicators of client progress to examine within this model might include school

performance, reduced legal problems, reduction in abuse of alcohol and other substances, improved knowledge about alcohol abuse and helping resources, and improved family relationships. Data generated by such evaluations could thereby promote a broader acceptance of the family systems approach.

A second recommendation is based on what we know about adolescent time perception. Initial treatment contracts should be set for 5 to 7 weeks which allows ample time to engage, but is not overwhelming. They should be very concrete and specific, containing feasible change objectives. Fees might be charged in advance for the entire contract in order to promote commitment to treatment. Therapeutic contracting with teenagers is most effective when their special needs are considered along with the family systems framework.

Referral sources should be employed extensively even beyond the point of referral. Aside from being a natural way of involving the external system, the referral source generally will be having continuing contact with the client family and can serve as almost a surrogate co-worker by supporting and reinforcing treatment efforts. We would therefore recommend that mechanisms for ongoing consultation be built into treatment contracts as well.

Innovative aftercare efforts are especially important with the population served by this model. Special periodic weekend events for families could be offered to those who

have graduated from primary treatment. These alumni retreats would provide structure for families to receive continued support, further family systems education, and define further areas of growth.

We are awaiting the results of the evaluation of the Youth Services Demonstration Project at Alcoholism Services of Cleveland because we believe they will support the use of the model presented in this paper.

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